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AUTHOR Chinard, Francis P.
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ABSTRACT

This report traces the evolution of a medical school from its beginnings as a private college affiliation, through its transformation into a state supported College of Medicine and Dentistry, to its emergence in Newark as the College of Medicine and Dentistry of New Jersey, N.J. Medical School. The school has survived the Newark riots, political difficulties, and numerous confrontations involving the community, faculty, students, and administration. Although the admissions rate of minority group students has increased over the years, as have the recruitments of U.S. nationals and U.S. graduates into the local residency programs, still those individuals have elected to practice elsewhere in New Jersey than in Newark after completion of training. Three main responsibilities are seen for the school and for the medical profession: (1) to provide medical care for all by means of physicians; (2) to provide access to the medical profession without regard to economic or social status; and (3) to develop models for the delivery of medical care by physicians in underserved areas. Tuition free entry into medical school and a stipend for all admitted with the provision of an obligatory service period on completion of training is proposed. (Author/MA)

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Francis P. Chinard, M.D.

College of Medicine and Dentistry of New Jersey - New Jersey Medical School

INTERACTIONS OF A DEVELOPING MEDICAL SCHOOL AND AN URBAN COMMUNITY

In response to the demand for more physicians in this country since World War II, the size of classes in each medical school has been expanded and new medical schools have been created. Concomitantly, there has been a deterioration of many urban centers where existing medical schools and their own or their affiliated hospitals have been situated with a resultant change in the clientèle cared for by these centers. The inner cities have become less secure and the middle class and the affluent have left and taken themselves and their problems elsewhere. Many "community" hospitals have relocated to the suburbs. New or developing medical schools, have, with one exception, been set up in the suburbs. The story of the exception, now known as the New Jersey Medical School, follows.

In 1949, following a substantial research and training grant application from the Jersey City Medical Center to the National Institutes of Health and a site visit, the suggestion came from the National Heart Advisory Council that the potential of New Jersey for medical education and research might best be tapped through a medical school to be established in Jersey City where the Medical Center could provide the necessary "clinical material" for a teaching program. Various manoeuvres followed involving Jersey City, the state of New Jersey and the American Medical Association which supported the development of a medical school (but preferably not in Jersey City). A state medical school was considered and a bond issue including funds for such a medical school was presented to the voters of the state in the early 1950's. However, in a counter move, the local catholic church authorities proposed a medical school with Seton Hall College as its academic filiation and the Jersey City Medical Center as its clinical and teaching center. Funds for the school would be provided from the church coffers through donations. The taxpayers of New Jersey would be spared direct contributions and the means would be available to attract more of the faithful to the medical profession in New Jersey. The bond issue was defeated and the Seton Hall College of Medicine was established. It gathered a small highly competent faculty, opened its doors to its first medical students in 1956, graduated its first class in 1960, and had gone broke and become a state supported institution by 1964 as the New Jersey College of Medicine and Dentistry. Despite these and other vicissitudes, the school prospered, gained significant recognition through its faculty which garnered a respectable total of federal funds for research, and through its students, many of whom indicated they would settle in the state to practice medicine.

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Unfortunately, there were increasing intrusions of Jersey City politics in the affairs of the school, the faculty and the hospital. The faculty and the Board of Trustees resented and resisted these intrusions and finally, the decision was reached to move out not only the clinical services but also the relatively unaffected basic science departments.

A number of locations for definitive settling had been considered and two types were examined with particular care. One was suburban in Madison in lovely rolling country, with small, affluent communities, well cared for by local physicians and community hospitals but needing a major referral center more accessible than New York or Philadelphia. An area of 150 acres, indicated by the trustees as being necessary to the full development of the medical center, was available. This was an ideal set-up for the continued development of middle-class medicine with the opportunity of providing for extension of the specialty concept in a referral center and was favored by trustees, administration, faculty and students. However, the degree of control thought necessary over a key community hospital could not be obtained. In addition, adequate access to "clinical teaching material" (i.e., patients on public wards) would be difficult to achieve. This "material" would be more readily accessible in an urban setting.

Newark, in contrast, offered substantial advantages. Its western zone was dominated by a large municipal hospital, the Newark City Hospital. Its beds were full, its services antiquated, its need for greater professional input immense. It could accommodate student and house staff teaching programs readily. Professional staff involved in the medical school's programs would be too busy to compete with the staff at the community hospitals that had remained in Newark and would take some of the pressures of the ghetto off these hospitals. There would be no problem in continuing to use the municipal hospital as a dumping ground for alcoholics, psychotics, drug addicts and tuberculous patients who, in addition to being unpleasant to deal with, generally did not have any money.

To the administration of the City of Newark the possibility of getting a medical school was enthralling. The municipal hospital was manifestly inadequate, there was no possibility of housing the basic sciences in existing structures and a substantial building program would have to be developed. This would mean jobs. In addition, if medical schools did have beneficial effects on patient care and health services a medical school in Newark would mean a substantial improvement in those areas.

By December, 1965, matters had come to a head in Jersey City. The Mayor's office had made a demand to which the trustees would not accede. Within 48 hours, the clinical departments had to relocate and the students in clinical clerkships had to scatter throughout the New York metropolitan area. Some departments were split between the Veterans Administration Hospital in East Orange and the Newark City Hospital. Had it not been for the support provided by the VA Hospital in East Orange and others, the medical school would have collapsed completely. A decision had to be made promptly about the definitive location of the medical school. Newark seemed the most appropriate but not necessarily the most desirable.

Initially, there was much opposition from the black community to the establishment of the medical school near the City Hospital in the Central Ward. (A separate University Hospital was originally planned). To make 150 acres

available would have meant to plow under innumerable houses crammed with black citizens with no place else to go. Few serious attempts were made to work with community leaders. Indeed, the trustees of the medical school reportedly demanded an area that was heavily populated in expectation that the demand would be rejected and that the college would be freed of any obligation to come to Newark. If this was a bluff, it was called by Addonizio with an immediate offer of land in early 1967. The bull dozers moved in, the people moved out and Newark blew apart in the summer of 1967. The Newark City Hospital, the intended temporary teaching center of the medical school, was referred to by the people and by the press as the "Butcher Shop" and the "Slaughter House". This intended move of the medical school was a significant factor in the riots. After the smoke had cleared, it was evident that if the move was to be made, it would have to be under terms different from those which had obtained originally: a take-over of the city hospital with no particular commitment to the community surrounding it.

Negotiations were undertaken by various groups representing the medical school, the state, the city and the federal government and community organizations. The discussions were prolonged, angry and bitter but agreements were finally thrashed out.

The medical school undertook to develop its programs on a limited tract of 57.9 acres and to provide medical care to the people of Newark on the same basis as the patients to be eventually admitted to the planned university hospital. To that end it took possession of and responsibility for the Newark City Hospital on July 1, 1968 with the understanding that the level of care was to be upgraded to that expected in a university hospital. Thus, for the first time a direct contractual obligation was undertaken by a medical school for delivery of medical services in its own hospital rather than in a hospital owned by a municipality. The medical school had made a formal commitment to serve the people of Newark. Of further particular importance, a Newark Community Health Council was to be established which would have the power to "review and approve programs to be developed and administered by the college to provide community health services to low-income persons in Newark". Other requirements included development of recruitment programs for minority group students and faculty establishment of special scholarship programs, for black and latin students, training opportunities for minority group members and employment in what was to amount eventually to a 200 million dollar medical-dental complex.

Many problems were encountered and many difficult situations had to be resolved. The stresses on individuals have been very great. Many of the senior faculty had left during the troubles in Jersey City. New faculty, recruited by a new and vigorous dean, found immense difficulties and many of these left the school or resigned from higher positions under fire or voluntarily. Thus, since 1967, the school has lost one president, two deans, four hospital directors, assorted and numerous administrators and nearly a dozen departmental chairmen. Community pressures may have been responsible for some of these departures. An important and positive role of the community has been achieved through a Board of Concerned Citizens appointed by the Board of Trustees of the school. This Board of Concerned Citizens came into being in 1970 when community members threatened to occupy the hospital because of grievances concerning employment, health care and patient amenities. It has played a role *inter alia* in the review of research programs involving patients, in devising means of helping disadvantaged students and in ensuring that the medical school would have a new hospital.

By all modern standards the Martland Hospital - ex Newark City Hospital - was inadequate and had to be phased out. The trustees of the medical school and the state authorities had obtained federal and state funds to build a "university" hospital. Unfortunately, the funds were fixed in dollar amounts and as the dollar shrank in value so did the size of the planned hospital. The only possibility would be to build a small referral hospital and to modernize Martland. The community response was direct and to the point. This plan would mean a nice new hospital for "whitey" and the same deplorable accommodations for the poor and the black of Newark. The plan would not fly. Now, some years later, after an approved bond issue, considerable pressures from many sources, including the Board of Concerned Citizens, a new hospital has emerged from the ground. Martland is to be phased out as a hospital for the acutely ill as soon as the new hospital is available.

This new hospital, the new medical sciences building, a mental health center, library and dental school, represent a total investment of some $200,000,000 in Newark. It is the result of the collaboration and of the conflicts of many diverse elements, many organizations and many individuals. This is the steel and concrete and this part is a success story. What about the students and the house staff?

Recruitment of minority students. In response to the agreements with the state, the school entered into an active recruitment program for minority students and the faculty undertook to provide special programs for those minority students who might need extra help. The minority statistics are indicated in Figure 1. For a school with about 110 positions in the first year, there is a nearly 20 fold greater number of applications. Of these, minority applicants represent a 10 to 20 percent segment. Of these, only 30 percent or so have qualifications appropriate for admission to medical school. And of these, the top group have found open doors at more solidly established medical schools, often anxious to change their image and to meet the requirements of equal opportunity legislation and affirmative action programs. Some of the medical students admitted in Newark had academic problems and those problems led to others.

Intensive tutorial help was given to the minority students by the faculty of the basic science departments. Indeed, some of the white students complained that they were not getting enough attention and latent hostilities surfaced. The problems worsened when it became evident that some of the minority students were not going to get through. Even if they were to be lifted over the hurdles they were not expected to be able to pass either National Board, Flex or state board examinations and, thus, would not be allowed to practice medicine. The Faculty Council met to consider the fate of six of these students. The Council's deliberations were abruptly interrupted by an invasion of community members led by one of our part-time faculty members, an activist probably influenced by Leroi Jones (Baraka) and by the writings of Franz Fanon. As he brought some 30 people into our meeting, this activist proclaimed repeatedly: "Ladies and gentlemen, you've got a problem." We did. But despite anger, hostility, and threats a dialogue was established. A reasonable decision was eventually reached and appropriate action taken (two of the students were dropped and four were required to repeat the freshman year).

From this encounter the faculty learned that it could not have a double standard in its admission policies. And the community recognized what would happen if inadequately qualified black physicians were graduated. As one black community member stated the problem "Who do you think they'll practice on? Us!"

There have been other confrontations, some even more threatening than the one just described. But, on the whole tempers seem to have cooled, there have been fewer accusations of discrimination, and at least superficially there appears to be an understanding and a common purpose.

House staff programs. An MD degree is not a license to practice. A minimum of three years of post-graduate training is recommended. In general, a resident will practice in or near the community where he has received his training. A measure of a medical school's standing and performance is how effective it is in recruiting its own graduates and in attracting graduates of other U.S. medical schools to Newark. As a paradigm, the Department of Medicine's achievements in this area are reviewed and summarized in Figure 2. There have been some problems. The nadir was reached in 1970. There has been substantial improvement since then although we would have expected more of our graduates to stay on in medicine out of the 130 or so currently graduating each year. Most have left and gone to more comfortable environments in New Jersey although some did go to comparable hospitals in New York City for a few years. The deficiency in numbers has been made up by a sprinkling of graduates of other U.S. medical and osteopathic schools, by U.S. graduates of schools at Guadalajara, Bologna and elsewhere and by a substantial input of foreign nationals from their own schools, with India and Pakistan our major sources. The late substantial increase in U.S. nationals from non-U.S. schools was due to the 5th channel programs. We are now recruiting mainly our own graduates.

In the residency years of the three year program there has been an increasing number of U.S. nationals. In the subspecialty programs, foreign graduates have predominated and most have stayed in the U.S. But there is steady increase of U.S. nationals in all the programs.

The graduates of the three year and of the subspecialty programs have settled in practice mainly in New Jersey but not in Newark. Many have privileges and take care of some of their patients in the private affiliated hospitals in Newark but their offices are where their clientele lives. Further, they frequently have their patients admitted to the outlying hospitals because of the apprehension that still exists about Newark. Many have part-time appointments at the medical school and share, to a limited extent, the responsibilities at the Martland Hospital. A very small proportion has stayed on the full-time staff.

The attractions of private practice in the affluent or developed area of the state still appear to be overwhelming. The presence of the medical school has so far had little positive effect on the number of physicians with offices in Newark. The hospitals remain in their pre-1967 role as the major providers of medical care to Newark.

Thus, Newark has provided physicians to the more affluent and developed parts of this country. Ironically, this drain has been met by draining away from India and other developing countries the educated and trained physicians for whom their own countries do not offer an adequate future.

Responsibilities and future directions. Traditionally, all medical schools, including the New Jersey Medical School, have responsibilities in three areas: teaching, research and service to patients. The New Jersey Medical School, however, has an additional categorical responsibility to the community which it serves and which includes more than just Newark. Considerable emphasis is placed ~~on~~ its role in Newark. One way of fulfilling that additional responsibility is to use all available means to induce students and house officers to serve the ghetto population and make this service their career goal. This policy would serve to institutionalize the ghetto and its underprivileged population as permanent features of our society. If, however, the ghetto is considered a social aberration to be corrected as quickly as possible other measures will be needed.

The role and the responsibility of the physician has been to provide a focal point for the patient in need of medical help and care, to arrive at a diagnosis, to recommend further work-up, to initiate and supervise treatment, to call in a specialist if required and to maintain continuity of care for the patient. Diagnosis may have been inaccurate and treatment ineffective, but nonetheless the demand of the public for this relationship has always been present. It has clearly not been met by the municipal hospitals.

The delivery of hospital based medical care could be made considerably more efficient than it is now in providing highly sophisticated but anonymous diagnostic and treatment facilities. Would this be considered sufficient by the ghetto resident? In these United States our goals in this area might be considered to make available to all what is available to the middle class as projected on the television screens. A system of medical care which does not provide individual physicians for a large segment of the population and does not plan for the availability of physicians in the future is unlikely to be acceptable to that part of the population - a part that may grow both relatively and absolutely and that has votes. That segment could justifiably say that it had been cheated again. More than the ghetto poor are involved in this eventual exclusion from the individual services of a physician. So are many of the lower middle class. State and federal taxes support all medical schools directly or indirectly. If the product of these schools is to be used mainly in providing service to the middle and the wealthy classes even though all segments of the population contribute through taxes to the education and training of physicians, a taxpayer revolt may well occur. It could come in the form of a national health scheme.

Questions for the future. Several questions face this medical school and the medical profession in Newark and New Jersey. What direction should the medical school take in its teaching and training programs? What should be done to meet the immediate needs with respect to health and medical care in the ghetto? How can access to the medical profession be provided for the most qualified? Granted that directions and goals can be defined, will anything get done?

The first question. To be responsive to the needs and the demands of the public and community that its graduates are to serve, the school must focus on programs which emphasize the traditional role of the physician. Thus, an appropriate foundation of knowledge and experience must be provided and training in the various specialties must also be available to provide back-up and expert knowledge for the management of patients with rarer or more complex disorders. But more physicians must serve in a primary role with direct patient contact and responsibility.

The second question. If the ghetto and poverty are considered social aberrations to be corrected as soon as possible, then social measures are needed. Housing, nutrition programs, education are areas over which the medical profession has but marginal control. However, there is need for providing much more physician time and effort in the ghetto, perhaps best in group practices, and for a de-emphasis of the hospital as the focus for medical care. Perhaps this increase of physician time in underserved areas (including affluent suburbia on Wednesdays, nights and week-ends) could be provided by the equivalent of a service period of two or more years in recognition and pay-back of the contribution made by all taxpayers to the education and training expenses of physicians.

The third question. Does the make-up of the medical profession, its social and economic origins, its largely middle class, affluent or wealthy background give an orientation to the profession's overall goals which gives inadequate consideration and material appropriate concern for the ghetto and the poor?

This is a matter of increasing urgency. The annual cost per medical student is estimated at 12 to 15 thousand dollars per year. Several schools, including our own, are charging up to 5 thousand dollars per year for tuition alone and two have gone above the 10 thousand dollar level. (Our fees were $1,750 per year for New Jersey residents and #3,000 per year for non-residents. They are now $3,000 per year for New Jersey residents and $5,000 per year for non-residents). Even if the money can be borrowed, on tuition alone this could amount to as much as $60,000 for a four year program. Many with the potential to be excellent physicians may turn to other occupations rather than incur such a heavy indebtedness before even getting to the opening of an office.

To continue in this direction is to deny access to the medical profession to all but the very wealthy. It is disconcerting to find little organized protest from the practicing physicians or from the academicians about the proposed and in some cases actual huge increases in tuition. Financially poorer but intellectually superior students will be scared off and the competition will be less for those with the means but with less than the optimal qualifications to go to medical school. A physician who can find ten to twelve thousand dollars per year to have his offspring go to medical school in Guadalajara or in Bologna will find it possible to pay that amount in tuition in the United States. With 14 percent of all students having a parent who is or was a physician (with well below one percent of the population being physicians), the conclusion could be reached by an extragalactic observer that American society believes in the inheritance of acquired professional characteristics.

The final question. Will anything get done? The medical profession and the medical schools have been far more responsive in the past than they have been given credit for and may have gone too far in some areas. Schools have taken on service responsibilities which have threatened their integrity as educational institutions and have tended to emphasize the vocational aspects rather than the scientific ones,to emphasize learning by rote and to use Procrustean approaches rather than understanding of disease processes and individualized consideration of the problems of a given human being, the patient.

As a profession, we can point out what health problems we recognize and indicate where we think action is needed. Thus, we can care for patients with tuberculosis but we cannot control or eradicate the conditions that led to the spread of the tuberculosis in crowded living quarters. We can correct vitamin

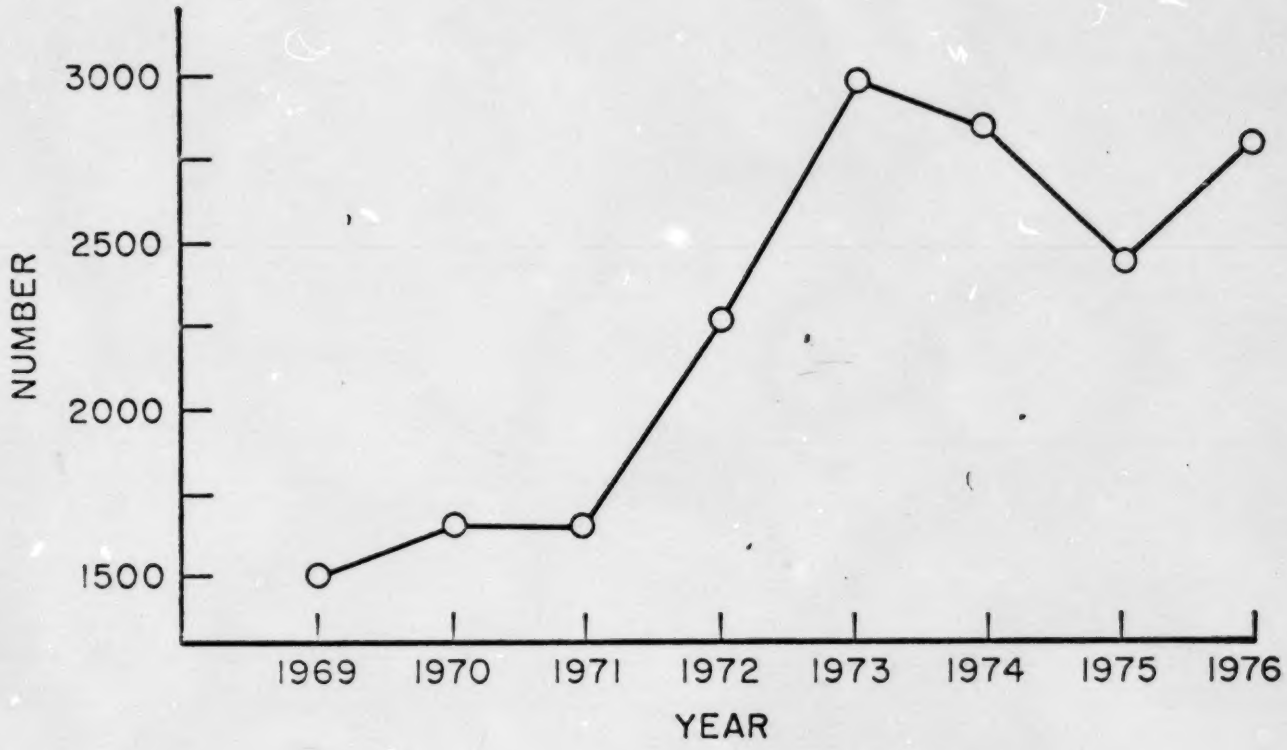
deficiencies but we cannot readily alter dietary habits of our patients. We can provide for more young people to go into public health fields but their effectiveness and ours will still be terribly limited. The responsibilities for the ghetto, for the malnutrition, for the alcoholism, for the drug addiction, for the lack of adequate immunization programs are society's. The issues are political, economic, social and educational. Improvement will require political action. The general public will have to set the economic, social and military priorities.

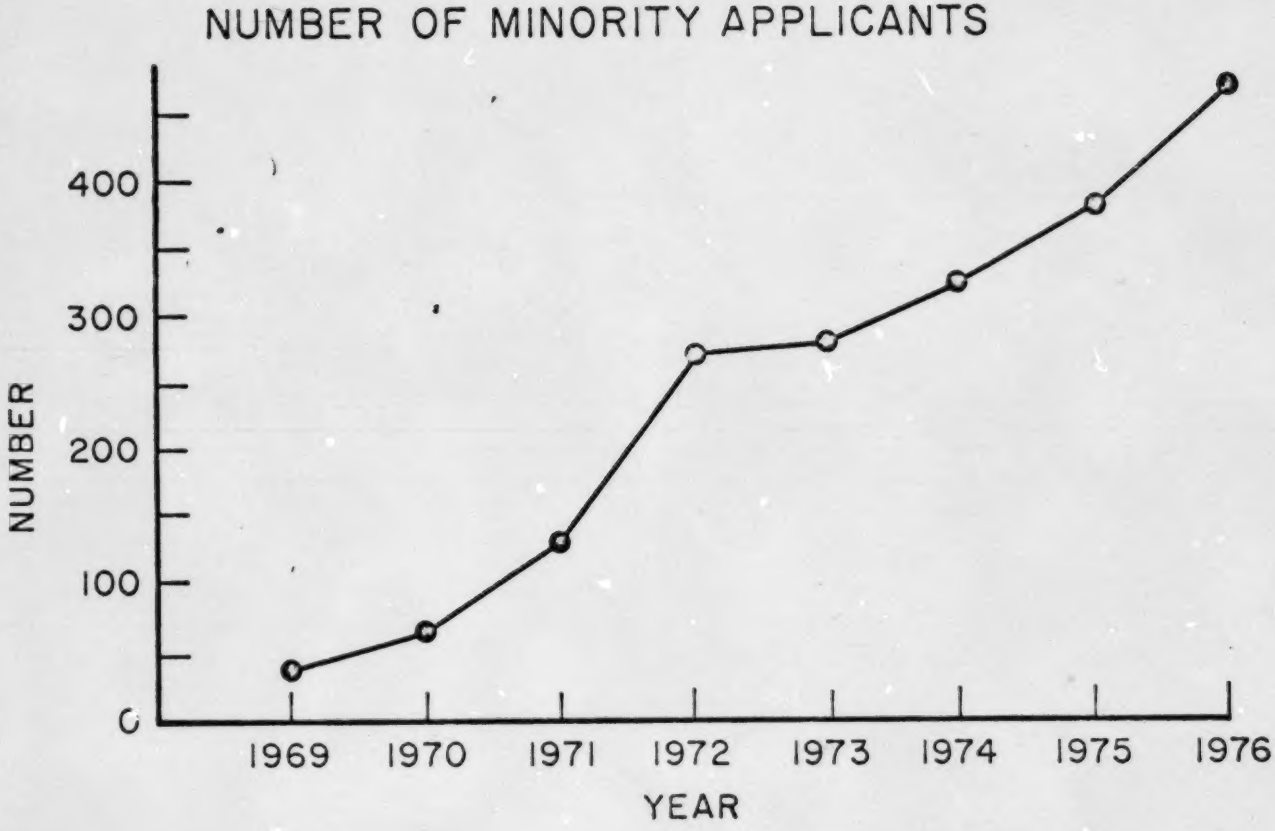
The medical profession and the schools can take a position of leadership by providing a mechanism for the provision of medical care, on an individualized basis where possible and appropriate, to those areas which are underserved or not served at all. Such a mechanism could be patterned on the relationships which already exist among the patients in the municipal hospital, the house officers who rotate through a service and the more permanent senior staff physicians. The latter provide some measure of the needed support for the patients over a period of many years while the younger resident staff take care of the more acute needs of the patients but enjoy less protracted patient-doctor relationships. Experiments along these lines have already been attempted but none has been an outstanding success. We have not been able to get many young physicians to set up individual or group practices in areas that are underserved and under-financed, and our graduates have on the whole gone after the money where it was. A service period could be intercalated on that pathway. It would have to be undertaken by all medical school graduates without exception for a period of two or more years. It would be service in ghettos, in emergency rooms and on the private as well as the "public wards" of community hospitals, in small towns or areas without medical services, and in federal programs. The back-up by more senior physicians could be provided in many ways. This service would be the quid for complete tuition remission and for the provision of a reasonable stipend during medical school. This tuition remission and the stipend would have to be provided for all students regardless of financial need so that the service years would be given by all regardless of income. Such a program would be expensive but society would more than recoup the cost in the provision of medical care in needful areas by physicians at salaries that could be between those of third year residents but less than the net incomes of established physicians. There is a precedent. Most graduates from 1940 to 1972 gave two or more years to the armed services.

Conclusion. Described here are some aspects of the events in the evolution of a medical school, designed on a middle-class model, and set down in a degraded, neglected and angry community which was just beginning to recover from a blood bath. The medical school came in, reluctantly, to bring the blessings of a more developed culture to the deprived and the disadvantaged of the ghetto. The minority groups--actually the majority in Newark--effectively took over and the school's status changed from invader and colonizer to besieged colonialist. More recently, the wastefulness of adversary tactics has been increasingly recognized and a reasonable modus vivendi has now been established. The relationships will continue to improve as long as there is dialogue instead of grandstanding and deliberate confrontation.

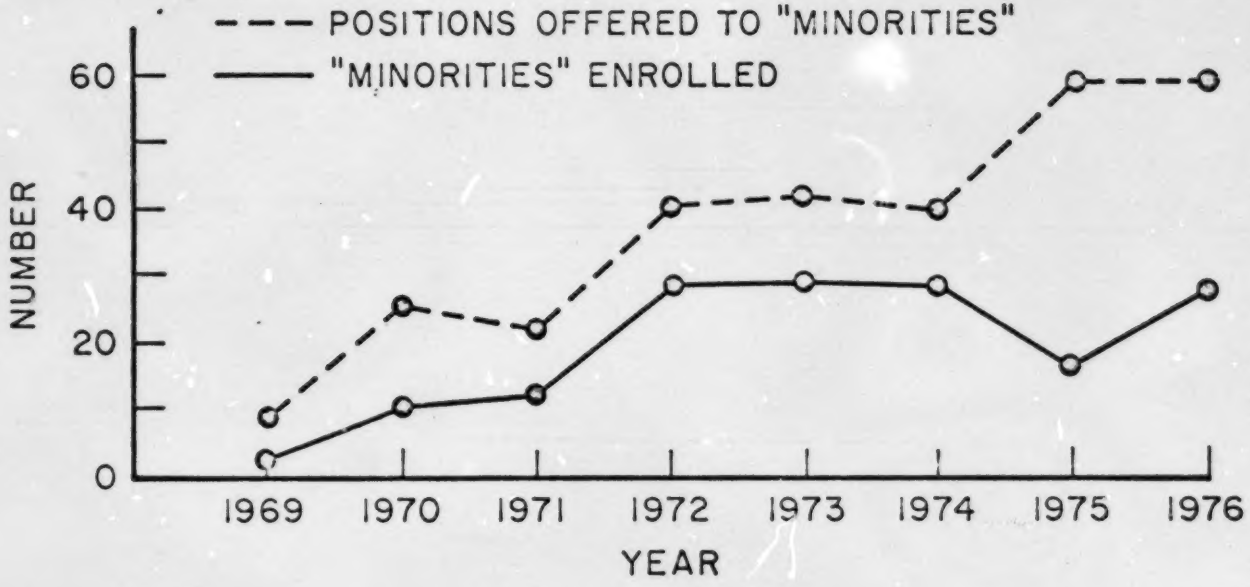
For the medical school and the medical profession there are three clear and dominant responsibilities. Access to medical care must be provided for all and that care must be provided by physicians. Access to the medical profession must be provided for all, regardless of economic or social status. Models for providing that medical care by the medical profession must be developed and implemented at least on a pilot scale.

TOTAL APPLICANT POOL
(CURRENT SLOTS 110)




NUMBER OF MINORITY APPLICANTS
NUMBER
400
300
200
100
0
1969
1970
1971
1972
1973
1974
1975
1976
YEAR

MINORITY POSITIONS VERSUS ENROLLMENT



NJMS INTERN RECRUITMENT (MEDICINE)

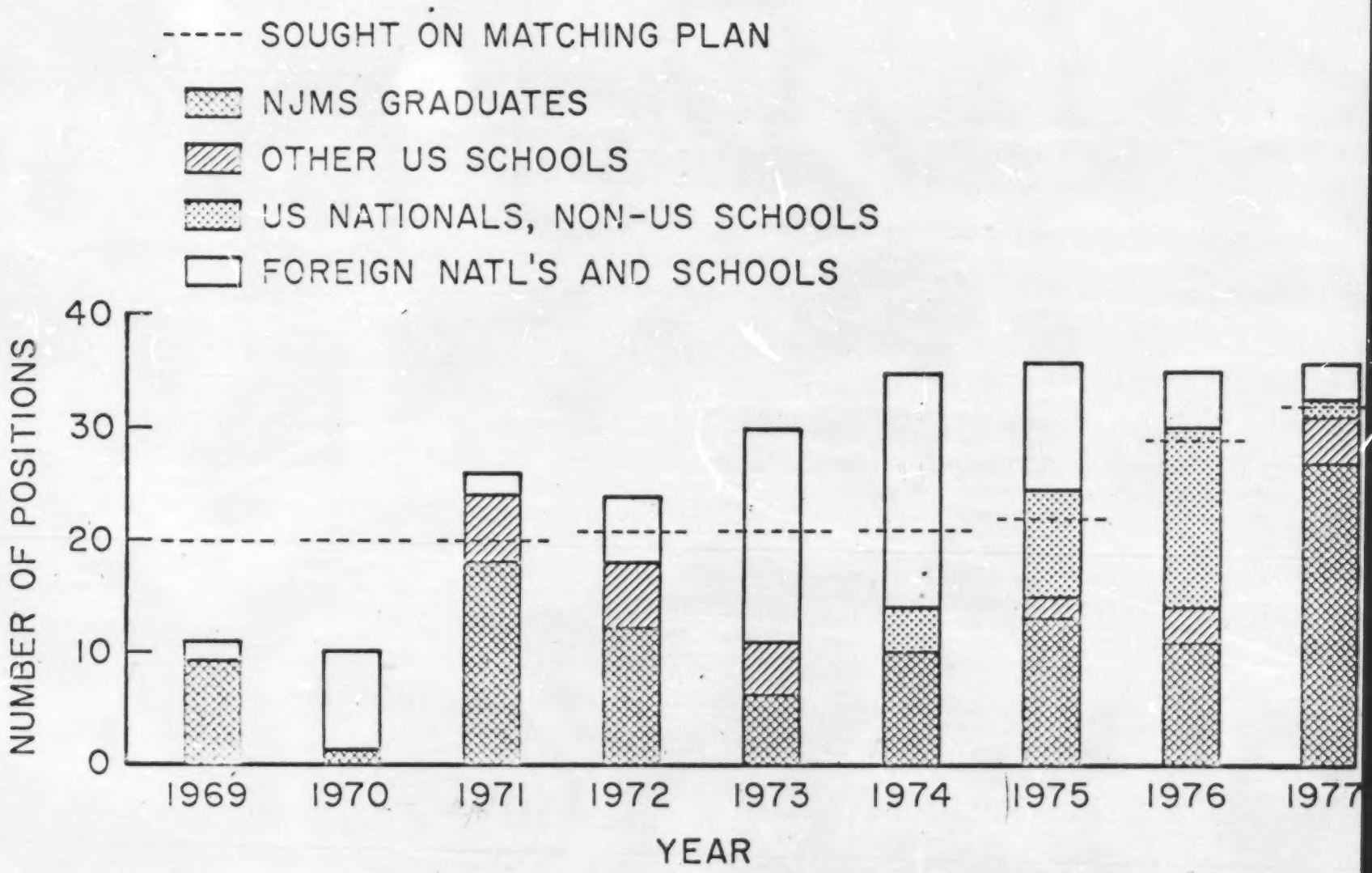


FIG 4

NJMS HOUSE STAFF RECRUITMENT (MEDICINE)

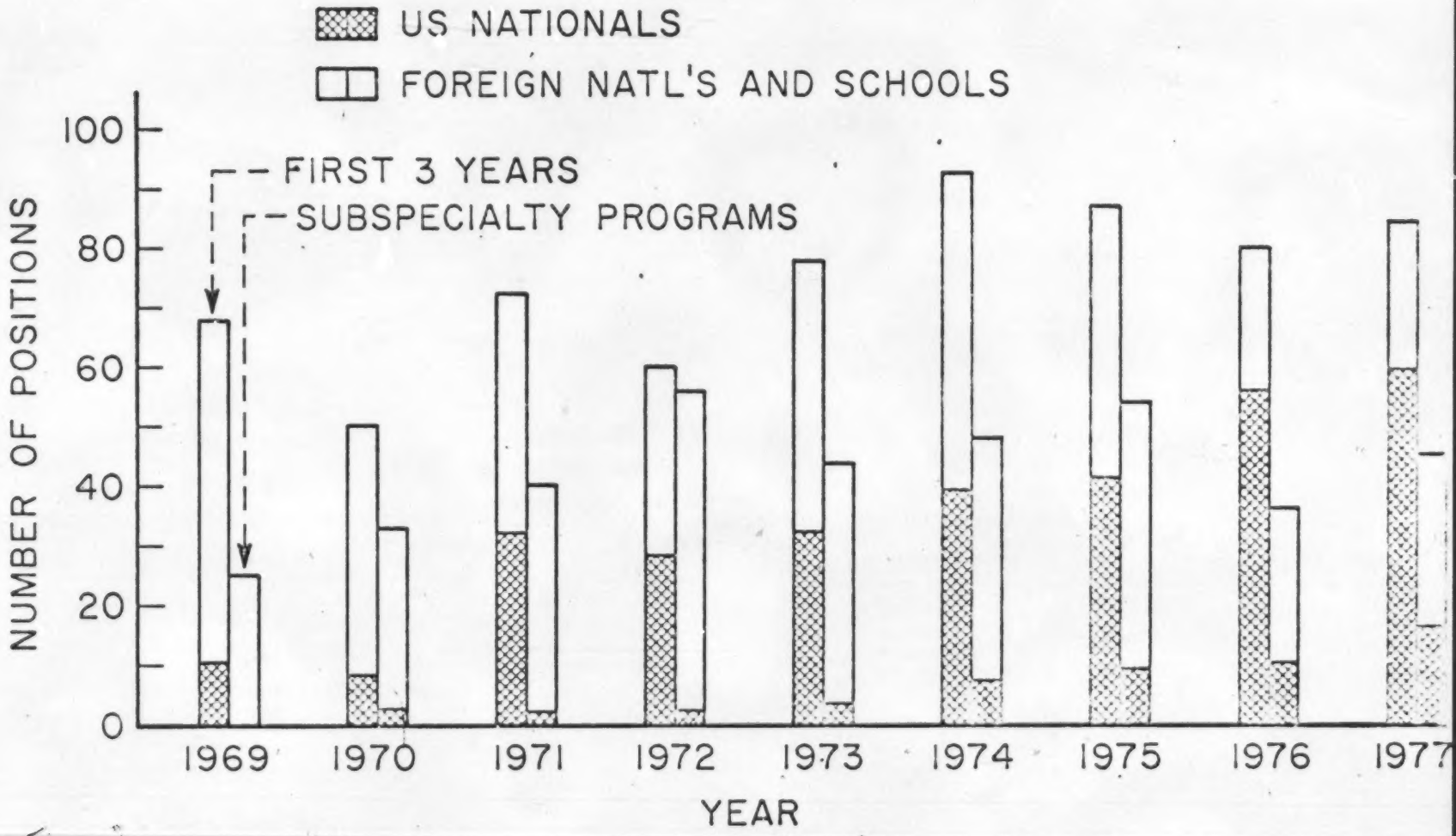


FIG 5

Legends to Figures

Figure 1. Total number of applications for admission to the New Jersey Medical School, 1969-1976.

Figure 2. Number of minority applicants, 1969-1976.

Figure 3. Number of minority applicants offered enrollment and number enrolled, 1969-1976.

Figure 4. Recruitment of interns to program of Department of Medicine, NJMS, 1969-1977. For 1969-1970, only Martland Hospital was involved. In 1971, the program of Veterans Administration Hospital was integrated with that at Martland. For 1973, the program at the Newark Beth Israel Hospital was also integrated. From 1973 on, the Department of Medicine filled all positions offered in the National Intern and Resident Matching Plan.

Figure 5. Recruitment of all house staff to programs of the Department of Medicine, 1969-1977. The first three years represent the internship and first and second years of residency in the general internal medicine program. The lag in recruitment of U.S. nationals to the sub-specialty programs (cardiology, renology, hematology, etc.) is to be noted.

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